Rural Carrier Benefit Plan 2000

A Managed Fee-for-Service Plan
With a Preferred Provider Organization

Sponsored by The National Rural Letter Carriers' Association

Who may enroll in this Plan: Only eligible active and retired rural letter carriers of the U.S. Postal Service are permitted to enroll in this Plan. To enroll you must also be, or must become, a member of the National Rural Letter Carriers' Association.

To become a member: For information on how to become a member of the National Rural Letter Carriers' Association contact your State Secretary's office or the National Rural Letter Carriers' Association.

Membership dues: Dues vary in each state.

Enrollment code for this Plan:
381 Self only
382 Self and family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at www.nrlca.org

Authorized for distribution by the:

UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT

Federal Employees
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Introduction

Rural Carrier Benefit Plan
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Alexandria, VA 22314-3466

This brochure describes the benefits you can receive from the Rural Carrier Benefit Plan under its contract (CS 1073) with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by the Mutual of Omaha Insurance Company, which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000 and are shown on page 4. You do not have a right to benefits that are available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to the Rural Carrier Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plan (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What to do if we deny your claim. This section tells you what to do if you disagree with our decision not to pay for your claim.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions-Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations-Rules that affect your benefits. This section describes limits that can affect your benefits.
9. Fee-for-Service Facts. This section contains information about pre-certification, protection against catastrophic expenses, and a definition section.
10. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1–Fee-for-Service Plans

Fee-for-Service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-Service plans let you to choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services varies by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a preferred provider organization (PPO) arrangement in certain locations in the following states: Alabama, Alaska, Arkansas, Washington DC, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2–How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copayment of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, and our networks.

If you have a chronic or disabling condition, or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the high option premium will increase by 17% for Self Only or 18% for Self and Family.
- The Plan has added a Preferred Provider Organization (PPO) benefit. PPO networks are available in certain locations in 28 States and Washington DC during 2000. Plan members who use preferred providers will receive covered services at a reduced cost.
- The Plan has removed the annual limit ($200) on routine physical examination charges under Other Medical Benefits.
- The Plan has increased the dollar limit from $200 to $300 under Additional Benefits for accidental injuries. The time period for care for an accidental injury has increased from 72 hours to 5 days.
- The Plan has reduced the deductible for inpatient hospital stays for Mental Conditions/Substance Abuse from $400 to $200 per person per calendar year. We also have adjusted the hospital benefit for inpatient stays from 100% for the first 31 days and 50% after 31 days to 100% for room and board and 80% for other hospital charges with no day limitation.
- The $250 limit for outpatient substance abuse care after an inpatient treatment program is removed. We will consider aftercare charges as part of the amount allowed for substance abuse treatment.
- The Plan has reduced from 100% to 85% the amount it will pay for professional fees for interpretation of x-ray and laboratory tests done in conjunction with outpatient surgery.
- The Plan has reduced the ambulance service benefit from 100% of the first $50 and 75% of the remaining charges after the $250 calendar year deductible to 75% of the charges after the $250 calendar year deductible.
- The Plan has reduced the consultation benefit from 100% of the first $50 and 75% of remaining charges after the $250 calendar year deductible to 75% of reasonable and customary charges after the $250 calendar year deductible.

Section 3–How to get benefits

How do I keep my health care expenses down?

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All FFS plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and flexible benefits option.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Mutual of Omaha's Care Review Unit before being admitted to the hospital. Be a responsible consumer. Be aware of your Plan's cost containment provisions. Avoid penalties and help keep premiums under control by following the procedures specified on pages 33 and 34 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

Preferred Provider Organization

This Plan offers its members who live in a Preferred Provider network area the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's Preferred Provider Organization (PPO). Consider the PPO cost savings when you review Plan benefits and if you live in a PPO network area check with the Carrier to find out which local facilities and providers are part of the network. Check with your doctor to see whether he or she has admitting privileges at a PPO hospital. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you choose not to use a PPO provider in your area, the normal non-PPO benefits apply.

In addition to a preferred provider network, your Plan has discount arrangements with other hospitals, physicians, and other medical facilities throughout the country with United Payers & United Providers (formerly America's Health Plan). Their terms vary, but the purpose is the same: to reduce your out-of-pocket expenses on covered services.

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of covered expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible is the $250 you pay before the Plan starts paying expenses for Other Medical Benefits.

Hospital

You pay $200 per person for the first non-PPO hospital admission in a calendar year before the Plan starts paying inpatient room and board benefits.

Dental

You pay a $50 deductible per person each calendar year for all dental procedures included in the Class B Schedule of Dental Allowances. You may count toward the deductible only those expenses covered under the Class B Schedule of Dental Allowances. You cannot count toward the deductible any charges in excess of the amounts listed in the Class B Schedule of Dental Allowances.

Mental conditions

For inpatient treatment of mental conditions you pay the first $200 of covered hospital charges per person each calendar year in a non-PPO hospital or facility.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of $250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members (1) after two family members have each met their calendar year deductible, or (2) when the combined covered expenses applied to the deductibles for all family members reach $500 during a calendar year.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge *or* the reasonable and customary charge, whichever is less. For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 80% of the allowance ($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5). Your total responsibility is $24.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 20% coinsurance, the actual charge is $80. The Plan will pay $64 (80% of the actual charge of $80).

When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 31), the Plan will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

Lifetime maximums

- Inpatient benefits for the treatment of alcoholism and drug abuse are limited to two inpatient programs per person per lifetime.
- The smoking cessation benefit is limited to one program per person per lifetime.
- Diagnosis and treatment of infertility is limited to $5,000 per person per lifetime.

Do I have to submit claims?

You usually do not have to submit claims to us, if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims within two years after the date you received the service or supply. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see Section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a Fee-for-Service Plan, you may choose any covered facility or provider.

Facilities and Other Providers

Covered facilities

Birthing center

A licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries and to provide immediate post-partum care.

Hospice

A public or private agency or organization that:

1) Administers and provides hospice care; and
2) Meets one of the following requirements:
   a) is licensed or certified as such by the State in which it is located;
   b) is certified (or is qualified and could be certified) to participate as such under Medicare;
   c) is accredited as such by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); or
   d) meets the standards established by the National Hospice Organization.

Hospital

(1) An institution which is accredited as a hospital under the hospital accreditation program of the JCAHO; or (2) any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with twenty-four-hour-a-day nursing service, and that is primarily engaged in providing: (a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or (b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities. In no event shall the term hospital include a convalescent nursing home or institution or part thereof that (1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged; (2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (3) is operated as a school.

For inpatient treatment of alcohol and drug abuse, the term hospital also includes a freestanding alcohol and drug abuse treatment facility approved by the JCAHO.

Skilled nursing facility

An institution or that part of an institution that provides convalescent skilled nursing care 24 hours a day and is certified (or is qualified and could be certified**)** as a skilled nursing facility under Medicare.

Covered providers

A licensed doctor of medicine (M.D.), a licensed doctor of podiatry (D.P.M.), or licensed doctor of osteopathy (D.O.). Other covered providers include a qualified clinical psychologist, clinical social worker, physician assistant, optometrist, dentist, chiropractor, nurse midwife, nurse practitioner/clinical specialist and nursing school administered clinic. For purpose of this FEHB brochure, the term “doctor” includes all of these providers when the services are performed within the scope of their license or certification.

A qualified clinical psychologist includes an individual who has earned either a Doctoral or Masters degree in psychology or an allied discipline and who is licensed or certified in the state where the service is performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she is qualifed to provide psychological services in that state by virtue of academic and clinical experience.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 2000, the States designated as medically underserved are: Alabama, Idaho**,** Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota**,** South Carolina, South Dakota, Utah, and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as doctors and other health care professionals, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this:

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you would usually pay a non-PPO provider. Although a PPO is not available in all locations or for all services, when you use these providers you help to contain health care costs and reduce what you pay in out-of-pocket costs. The selection of PPO providers is solely the Carrier's responsibility, and continued participation of any specific provider in the PPO cannot be guaranteed.

While PPO providers agree with the Carrier to provide services, the final decision about health care is the responsibility of the doctor and the patient. Benefit decisions made by the Carrier are dependent on the terms of the insurance contract. PPO benefits apply only when you use a participating PPO provider. If no PPO provider is available, or you choose not to use a PPO provider when one is available, the normal non-PPO Plan benefits apply.

When you use a PPO hospital, please keep in mind that the health care professionals who provide services to you in the hospital, such as radiologists, anesthesiologists, and pathologists, may not all participate in the PPO. If they do not participate in the PPO, they will be paid as non-PPO providers by the Plan.

The Plan pays its normal benefits to non-PPO facilities and providers for services and you are responsible for any balance due.

This Plan's PPO

Plan members who live in certain parts of the country may use a Preferred Provider Organization (PPO) network of hospitals, health care facilities, doctors, and other health care professionals. PPO networks are located in certain areas of the following states: Alabama, Alaska, Arkansas, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin and Washington DC. These PPO providers agree to render services to Plan members and their dependents for a negotiated fee. You can choose a PPO provider or a non-PPO provider at the time care is needed.

If a Plan member uses a PPO hospital, the $200 deductible and the 20% coinsurance are waived for medical, surgical and maternity stays. If the hospital stay is for mental health care in a PPO hospital or facility, the $200 deductible and the 20% coinsurance are waived. When a PPO doctor performs surgery, the Plan pays 90% of the surgeon's negotiated fee. For PPO doctor office visits, the Plan pays 100% of the negotiated fee after you pay a $15 copayment per visit. For other services provided, the PPO pays doctors and other health care professionals under Other Medical Benefits at 85% of the negotiated fee after a $250 deductible per person each calendar year.

When you are admitted to a PPO hospital, show your Rural Carrier Benefit Plan (RCBP) identification card to the Admissions Department. Please advise the admissions staff that the RCBP participates in the PPO program and complete an assignment of benefits to the hospital. The hospital will file the claim for you and the benefits will be paid to the hospital. Plan members who live in a PPO area will receive a listing of the participating hospitals and health care facilities in the service area.

Follow the same procedure when you receive services from a PPO doctor. Doctors and other health care professionals are generally located in the same location as PPO hospitals. For information on the specialists, general practitioners and hospitals in your area, please call 1-800/638-8432 or refer to the Carrier's Web site at http://www.mutualofomaha.com/service/provider/index.html. The Carrier is solely responsible for selecting PPO providers and any questions about PPO providers should be directed to Mutual of Omaha at 1-800/638-8432.

What do I do if I'm in the hospital when I join this Plan?

First, call Mutual of Omaha's Customer Service Department at 1-800/638-8432. If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternate care center, or
- You exhaust the benefits available from your former plan, or
- The 92nd day after you become a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester of pregnancy. Your new plan will pay for your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in the second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

How do you decide if a service is experimental or investigational?

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished to you. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Section 4–What to do if we deny your claim or request for preauthorization

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedure performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for pre-authorization or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial. We may extend this time limit if you can show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Approve your request for pre-authorization; or
3. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review a denial after you ask us to reconsider our initial denial. OPM will determine if we correctly applied the terms of our contract when we denied your claim.

What if I have a serious or life threatening condition and you haven't responded to my request for pre-authorization?

Call us at 1-800/638-8432 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your request, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's Health Benefits Contract Division II at 1-202/606-3818 between 8 a.m. and 5 p.m. Serious or life threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Section 4–What to do if we deny your claim or request for preauthorization *continued*

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claim file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5–Benefits

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 33 and 34 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States. For information on when Medicare is primary, see page 29.

Room and board

For each confinement, the Plan will consider semiprivate or ward accommodations in a hospital to include all nursing care, meals and special diets. The Plan will consider charges for accommodations in intensive care units for each confinement, even though these charges may exceed the hospital's semiprivate room rate.

If a private room is used, the Plan will consider the average semiprivate room rate charged by the hospital or, if the hospital has only private rooms, the average semiprivate rate for hospitals in the same geographic area. However, if the patient's isolation is medically necessary to prevent contagion to others, the private room charge will be considered.

PPO benefit

The Plan pays room and board at **100%** with no deductible when admission is to a PPO hospital. See page 8.

Non-PPO benefit

After you pay a $200 deductible for the first admission in a calendar year, the Plan pays **100%** of the semiprivate room and board charges.

Other charges

Other charges include, but are not limited to:

- Use of operating room
- Surgical dressings
- Drugs and medicines for use in the hospital
- X-ray and laboratory examinations
- Blood or blood plasma, if not donated or replaced, and its administration

PPO benefit

The Plan pays other hospital charges at **100%** when admission is to a PPO hospital. See page 8.

Non-PPO benefit

The Plan pays other hospital charges at **80%**.

Limited benefits

Pre-admission testing

The Plan pays **100%** of reasonable and customary charges for pre-admission testing received within 7 days of admission as an inpatient to a hospital.

Hospitalization for dental work

The Plan pays Inpatient Hospital Benefits in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

Related benefits

Consultations

Inpatient consultations are covered under Other Medical Benefits (see page 18).

Professional charges

Charges for professional services of a doctor, even though billed by a hospital as part of the hospital services, are covered under Other Medical Benefits (see page 18).

Prosthetic appliances

Prosthetic appliances (e.g., pacemakers, artificial hips, intraocular lenses) provided by a hospital are covered under Other Medical Benefits (see page 18)

Take-home items

Drugs and medicines and other medical supplies furnished upon discharge for use at home are covered only under Other Medical Benefits (see page 18) or Prescription Drug Benefits (see page 22).

What is not covered

- A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Confinement in nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility or hospice (see definitions)
- Custodial care (see definition) even when provided by a hospital
- Inpatient private duty nursing
- Personal comfort items such as radio, television, telephone, air conditioner, beauty and barber services, guest cots, guest meals, newspapers and similar items

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient and outpatient

Charges for normal pre- and post-operative care by the doctor, who performs surgery, including inhospital visits for the first 14 days after an operation, are considered to be part of the surgical fee. Hospital visits by the surgeon after 14 days are considered under Other Medical Benefits (see page 18). Charges for use of an outpatient surgical facility are covered as Additional Benefits (see page 21).

PPO benefit

If a PPO doctor performs the surgery, the Plan will pay **90%** of the surgeon's negotiated fee for the inpatient or outpatient surgical procedure; see page 8.

Non-PPO benefit

The Plan pays **85%** of the reasonable and customary charges for inpatient or outpatient surgery by a non-PPO doctor.

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session by a doctor/surgeon or podiatrist, the Plan pays as follows: the value of the major procedure plus **50%** of the value of the lesser procedure(s) will be considered.

Incidental procedures

When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of scar) is performed through the same incision, the reasonable and customary allowance will be that of the major procedure only. Separate benefits will not be provided for procedures deemed by the Plan to be incidental to the total surgery.

Assistant surgeon (inpatient/outpatient)

The Plan pays **85%** of reasonable and customary charges of an assistant surgeon for inpatient or outpatient surgery when determined by the Plan to be medically necessary.

Second opinion (voluntary)

The Plan pays **100%** of reasonable and customary charges for a second, outpatient surgical opinion by an independent consulting doctor other than the surgeon.

Anesthesia

The Plan pays **85%** of the reasonable and customary charges for general anesthesia and its administration.

Organ/tissue transplants and donor expenses

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury.

What is covered

- Cornea, heart, kidney, liver, pancreas (when condition is not treatable by use of insulin therapy), heart/lung, single lung and double lung transplants
- Bone marrow transplants and stem cell support as follows: allogeneic bone marrow transplants; autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, epithelial ovarian cancer, breast cancer, and multiple myeloma
- Related medical and hospital expenses of the donor when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

What is not covered

- Transplants not listed as covered

Cosmetic surgery

Cosmetic surgery (see definition) is covered only if necessary for repair of accidental injury sustained while covered by the FEHB Program, to correct congenital anomalies, or for reconstruction of a breast that was removed or partially removed.

Oral and maxillofacial surgery

Oral surgery is covered only for:

- The extraction of impacted (unerupted) teeth
- Correction of fractures of the jaw and/or facial bones
- Removal of salivary stones
- Correction of cleft palate
- Correction of severe malocclusion (protruding or retruding mandible or maxilla) caused by disease, injury, or congenital malformation
- Excision of bony cysts of the jaw (unrelated to tooth structures)
- Excision of pathological tori, tumors, and premalignant and malignant lesions
- Surgical correction of temporomandibular joint (TMJ) dysfunction
- Dental surgical biopsy
- Frenectomy or frenotomy unrelated to orthodontic care

Mastectomy surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

Benefits will be provided for breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including the treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements (see page 18).

What is not covered

- Treatment or removal of corns and calluses, or trimming of toenails
- Radial keratotomy or similar surgery done in treating myopia (except for cornea graft)
- Dental appliances, study models, splints and other devices or services related to the treatment of TMJ dysfunction
- Reversal of voluntary surgical sterilization

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury**.** The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 33 and 34 for details.

Room and board

PPO benefit

The Plan pays room and board at **100%** with no deductible when admission is to a PPO hospital. See page 8.

Non-PPO benefit

After you pay a $200 deductible for the first admission in a calendar year, the Plan pays **100%** of the semiprivate room and board charges.

Other charges

Bassinet or nursery charges for days on which mother and child are both confined are considered expenses of the mother and not expenses of the child. Doctor's in-hospital charges for routine newborn care and any other charges which are expenses of the child, will be considered only if the child is covered by a family enrollment. Routine circumcision is covered under Surgical Benefits for family enrollments.

PPO benefit

The Plan pays other hospital charges at **100%** when admission is to a PPO hospital. See page 8.

Non-PPO benefit

The Plan pays **80%** of other hospital charges.

Outpatient care

The Plan pays **100%** of the reasonable and customary charges for covered services at the time of delivery when:

- Delivery is on an outpatient basis, or
- Delivery is at a licensed birthing center, or
- Inpatient delivery results in a hospital confinement of one day (overnight) or less

If the mother or newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid at **100%** of reasonable and customary charges.

For a confinement of one-day (overnight) or less, if the mother and child leave the hospital against medical advice, this benefit is not payable and only the regular Plan benefits will apply.

Obstetrical care

Prenatal and postpartum doctor and midwife visits are covered under Other Medical Benefits (page 18).

PPO benefit

If a PPO provider performs the delivery, the Plan will pay **90%** of the negotiated fee. See page 8.

Non-PPO benefit

The Plan will pay **85%** of the reasonable and customary charges for delivery by a doctor or midwife.

Maternity Benefits

Related benefits

Diagnosis and treatment of infertility

Services for the diagnosis and treatment of infertility are covered under Other Medical Benefits (see page 19).

Tests

Sonograms, amniocentesis and other related tests on the unborn are covered under Other Medical Benefits (see page 18).

Voluntary sterilization

The Plan pays the same benefits as for any other surgical procedure. See Surgical Benefits (page 13).

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services and supplies related to treatment of impotency
- Reversal of voluntary surgical sterilization
- Assisted Reproductive Technology (ART) procedures**,** such as artificial insemination, in vitro fertilization, embryo transfer or placement and GIFT. Services and supplies related to ART procedures are not covered.

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Inpatient care

The Plan pays for inpatient care as shown below.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 33 and 34 for details.

PPO benefit

The Plan pays **100%** of the room and board charges and other hospital charges with no deductible when admission is to a PPO hospital or facility. See page 8.

Non-PPO benefit

After a $200 deductible per person per calendar year, the Plan pays **100%** of the room and board charges and **80%** of other charges.

Partial hospitalization

If you or a covered family member incurs expense for partial hospitalization, the Plan will pay for each day of confinement as follows:

- Benefits payable are subject to the same limitations and conditions, including precertification, as for inpatient care; and
- At least four hours of continuous treatment, but not more than 12 hours, in any consecutive 24 hour period in a hospital

Partial hospitalization must be a medically necessary alternative to inpatient hospitalization.

Catastrophic protection benefit

When the 20% you pay for covered hospital charges and the deductible (non-PPO) totals $8,000 in a calendar year for one member, the Plan will then pay 100% of that person's covered hospital charges for the rest of that calendar year.

Inpatient/ outpatient visits

The Plan will consider charges for psychiatric treatment sessions (including group sessions) up to a maximum benefit of $75 per session even when billed by a hospital or provided by the hospital staff. These services are covered only when rendered by a covered provider (see pages 7 and 8), even when billed for by a hospital or provided by hospital personnel. These services are not subject to a deductible or coinsurance and their cost does not apply to the catastrophic protection benefit for mental conditions. Charges for psychological testing and pharmacological visits are covered under Other Medical Benefits (see page 18). The medical management of mental conditions will be covered under Other Medical Benefits (see page 18). Related drug costs will be covered under the Plan's Prescription Drug Benefits (see page 22).

Substance abuse

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 33 and 34 for details.

PPO benefit

The Plan will pay up to $6,000 for inpatient care in a PPO facility or outpatient care by a PPO provider. See page 8.

Non-PPO benefit

The Plan will pay up to $5,500 for an inpatient treatment program in an accredited facility or an outpatient treatment program.

Lifetime maximum

The Substance Abuse Benefit is limited to two inpatient programs per person per lifetime. No other benefits are payable for this condition.

What is not covered

- All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)
- Biofeedback and milieu therapy
- Counseling or therapy for educational or behavioral problems, or related to mental retardation or learning disabilities.
- Marital, family or other counseling services

Other Medical Benefits

What is covered

Physician visits

PPO benefit

The Plan pays in full after a $15 copayment for each covered outpatient visit. The $250 deductible does not apply to this benefit and the copayment does not count toward the out-of-pocket limit. The copayment applies to each visit and only one copayment will be applied per day per person. Coverage is provided for the following services performed in a physician's office:

- Office visits, including consultations;
- Ophthalmology exam;
- Physical therapy;
- Surgery follow-up;
- Injections, including allergy injections;
- Allergy testing;
- Radiation therapy; and
- X-ray and laboratory services in the physician's office.

The $15 copayment and 100% benefit does not apply to office surgery, prescription drugs and any supplies provided by the physician and services not received in the physician's office.

Non-PPO benefit

After the $250 calendar year deductible, the Plan pays **75%** of reasonable and customary charges.

Other Services

PPO benefit

After the $250 calendar year deductible, the Plan pays **85%** of the PPO provider's negotiated fee. See page 8.

Non-PPO benefit

After the $250 calendar year deductible, the Plan pays **75%** of the reasonable and customary charges.

Covered services and supplies

Coverage is provided for the following other services when prescribed by a physician:

- Hospital visits and inpatient consultations
- Prenatal and postpartum physician and midwife visits
- Insulin, including syringes
- Physical therapy performed by a registered physical therapist
- Oxygen and equipment for its use
- Electroshock therapy
- Radiation therapy
- Chemotherapy
- Allergy treatment, including injections and testing
- Purchase of one pair of eyeglasses or contact lenses required after intraocular surgery within one (1) year of the surgery. Spare glasses or lenses are not covered after surgery.
- Hospital outpatient services and supplies
- Speech therapy by a qualified speech therapist when loss of speech is due to illness or injury
- Rabies shots when the individual has been exposed to active rabies
- X-ray and laboratory examinations except for dental work
- Pathological services and machine diagnostic tests
- Orthopedic appliances, including orthopedic braces and crutches
- Prosthetic appliances such as artificial limbs, joints, and eyes, including replacement, repair, or adjustment when required because of a change in the patient's physical condition.
- Breast prostheses (including the surgical bra used for an external prosthesis) following a mastectomy. In addition to the initial prostheses following mastectomy, we will provide necessary replacement prostheses and bras.
- Professional ambulance service to the nearest hospital or medical facility equipped to handle the patient's condition for accidents, acute illnesses or for covered inpatient care.

Preventive services

PPO benefit

The Plan pays in full after a $15 copayment for the physician's professional fee and services provided in the physician's office. For all other services and supplies provided on an outpatient basis, the Plan pays **85%** of the covered charge after the $250 calendar year deductible.

Non-PPO benefit

After the $250 calendar year deductible, the Plan pays **75%** of the reasonable and customary charges.

The Plan pays for the following preventive services:

Physical exam

We pay for one routine physical exam per person per calendar year. A routine physical exam is a complete evaluation of a patient without symptoms or illness and includes a comprehensive history and physical examination.

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period;
- From age 40 through 64, one mammogram screening every calendar year; and
- From age 65 and over, one mammogram screening every two consecutive calendar years.

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening

Annual coverage of one fecal occult blood test for members age 40 and older. For members age 50 or older, coverage of a screening sigmoidoscopy every five years.

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Limited benefits

PPO benefit

After the $250 calendar year deductible, the Plan pays **85%** of the PPO provider's negotiated fee. See page 8.

Non-PPO benefit

After the $250 calendar year deductible, the Plan pays **75%** of the reasonable and customary charges.

Chiropractor

Plan pays up to $300 per person each calendar year for service of a chiropractor. Services of a chiropractor are not covered under any other Plan benefit except as described on page 8. Chiropractic charges applied to satisfy the deductible are counted toward the benefit limit.

Diagnosis and treatment of infertility

The Plan will pay up to $5,000 per person per lifetime for the following services and supplies:

- Initial diagnostic tests and procedures done solely to identify the cause of the inability to conceive
- Fertility drugs, hormone therapy and related services
- Medical or surgical services performed solely to create or enhance the ability to conceive

Durable medical equipment

The Plan pays for rental, up to the purchase price, of durable medical equipment (see definition). Purchase of equipment is at the Plan's option and must also be preapproved. To obtain preapproval, request Plan approval in writing within 31 days of the initial rental and include your doctor's statement of medical necessity. Unless you request an extended rental within 31 days, the Plan will not pay for more than three rental months even if it eventually authorizes purchase of the equipment.

Occupational therapy

Plan pays for up to 30 days of occupational therapy each calendar year when therapy is under the supervision of a doctor.

Smoking cessation benefit

The Plan will pay up to $100 per member per lifetime for enrollment in one smoking cessation program, including any related prescription drugs. Charges applied to satisfy the deductible are counted toward the benefit limit. Smoking cessation drugs and medications are not available under any other Plan provisions.

Well child care

The Plan will pay charges for all routine office visits and testing for children up to age 24 months. See Additional Benefits for the benefit for routine childhood immunizations.

What is not covered

- Orthopedic shoes, orthotics and other devices to support the feet
- Corsets and trusses
- Provocative food testing, end point titration techniques and sublingual allergy desensitization
- Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, exercise devices and other items that do not meet the definition of durable medical equipment
- Eye exercises and visual training (orthoptics)
- Custodial care (see definition)
- Telephone consultations
- Jobst stockings, unless determined to be medically necessary

Additional Benefits

Accidental injury

If you or a family member is accidentally injured, the plan will pay **100%** of reasonable and customary charges up to the maximum benefit for:

- Surgery and medical care by a physician
- Hospital room and board and other related services and supplies
- Private duty nursing services in your home by a registered graduate nurse (R.N.)
- X-ray and laboratory tests
- Drugs and medicines
- Casts, splints, braces, and crutches
- Surgical dressings

To be eligible for benefits under this provision, initial and follow-up care must be received within 5 days of the injury or medical emergency.

Maximum benefit

PPO benefit The Plan will pay up to $500 if you receive care from a PPO provider. See page 8.

Non-PPO benefit The Plan will pay up to $300 if you receive care from a Non-PPO provider.

Charges exceeding the maximum benefit will be considered under Other Medical Benefits.

Cancer treatment

The Plan will pay, without dollar limitation, **100%** of the reasonable and customary charges for any services and supplies normally covered by the Plan for the treatment of any illness diagnosed as cancer. The service or supply must be for the treatment of a malignancy. Diagnoses secondary to cancer are not covered under this benefit.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at **100%** of reasonable and customary charges for dependent children under age 22. Associated charges for office visits and other services will be considered under Other Medical Benefits.

Dental accident

The Plan will pay **100%** (no deductible) of reasonable and customary charges for the treatment or repair (including root canal therapy and crowns) of an accidental injury to sound natural teeth (not from biting or chewing), provided the accident occurs while covered by the FEHB Program, and the treatment or repair is performed within one year of the accident. If treatment or repair to a child's teeth must be delayed because of the child's age, the Plan may extend coverage to a period of not more than three years from the date of the accident provided the request for delay is made to the Plan within one year of the accident, and the child remains covered by the Plan until treatment is completed.

The Plan may request dental records, including X-rays, to substantiate the condition of the teeth prior to the accidental injury. Charges covered for dental accidents cannot be considered under Dental Benefits.

Home health care

If home health care (see definition) is precertified (see page 34), the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $80 per visit for up to 90 visits per calendar year when the care is an alternative to hospitalization.

If the care is not precertified, the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $40 per visit for up to 40 visits per calendar year when the care is an alternative to hospitalization.

A home health care visit consists of one of the following:

- Less than an 8 hour shift of nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN);
- One session of physical, occupational or speech therapy provided by a licensed therapist;
- Less than an 8 hour shift of a home health aide's services that are performed under the supervision of a registered nurse (RN) and that consists mainly of medical care and therapy provided solely for the care of the Plan member.

The above services must be furnished by a home health agency (or by visiting nurses where services of a home health agency are not available) in accord with a home health care plan (see definition) certified by the member's doctor and in the member's home.

Hospice care

If hospice care is precertified (see page 34), the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $7,500 for care provided by a hospice agency or organization (see definition) to a terminally ill patient in the final stages of illness when such care is prescribed by a doctor.

If the care is not precertified, the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $5,500 when a doctor prescribes hospice care.

Outpatient surgical facility

The Plan will pay **100%** of charges for the use of an outpatient surgical center or other outpatient surgical facility, including a doctor's office. The doctor's charge for surgery is covered under Surgical Benefits (page 13).

Renal dialysis

The Plan will pay **100%** of reasonable and customary charges for covered services and supplies for renal dialysis in or out of the hospital.

Skilled nursing facilities

If a person is confined in a skilled nursing facility and the confinement is precertified (see page 34), the Plan will, for a maximum of 60 days per calendar year, pay **100%** of the reasonable and customary charges when the confinement is an alternative to hospitalization.

If a person is confined in a skilled nursing facility but the confinement is not precertified, the Plan will, for a maximum of 30 days per calendar year, pay **80%** of the reasonable and customary charges when the confinement is an alternative to hospitalization.

Vision care

The Plan will pay up to $45 per person per calendar year for one routine eye examination**,** including eye refraction, if part of the routine exam. Please note that the itemized bill must indicate that the visit is for the purpose of a routine exam.

Prescription Drug Benefits

What is covered

You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:

- Drugs that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and syringes for the administration of covered medication
- FDA approved prescription drugs and devices for birth control
- Ostomy and colostomy supplies

What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes
- Nutritional supplements, vitamins
- Fertility drugs, after the Plan's payment for the treatment of infertility has met the $5,000 lifetime maximum
- Drugs to aid in smoking cessation except under Smoking cessation benefit (see page 19)
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law
- Drugs to treat sexual dysfunction and impotence

From a pharmacy

You may purchase up to a 34-day supply of covered drugs or supplies at a discount through a Caremark Retail Network Pharmacy or pay full price at a non-network pharmacy. Call 1-800/831-4440 to locate a network pharmacy in your area. You pay the cost of a prescription at the time of purchase. The expense is reimbursed at **75%** after the $250 deductible has been met.

To claim benefits

Use Plan claim form HCFA 1500 to claim benefits for prescription drugs and supplies you purchased at any network or non-network retail pharmacy. You may obtain claim forms by calling 1-800/638-8432. Complete and sign the claim form, attach prescription receipts and mail it to: Rural Carrier Benefit Plan, P.O. Box 668329, Charlotte, NC 28266-8329. Your receipt must show the patient's name, prescription number, name of drug, prescribing doctor's name, date, charge, and name of pharmacy.

By mail

If your doctor orders more than a 34-day supply of drugs or covered supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Rural Carrier Benefit Plan mail order drug program. Caremark will fill your prescription. All drugs and supplies covered by the Plan are available under this program except drugs to aid in smoking cessation and fertility drugs.

Under the Rural Carrier Benefit Plan mail order drug program, if a generic equivalent to the prescribed drug is available, Caremark will dispense the generic equivalent instead of the brand name unless your doctor specifies that the brand name is medically required. You pay a $15 copayment for each brand name prescription drug and a $10 copayment for each generic prescription drug or refill you purchase through the Plan's mail order drug program.

Medicare copayment

You pay a $5 copayment for each brand name or a $2 copayment for each generic prescription drug or refill when you are covered by Medicare Part B and use the Plan's mail order drug program.

To claim benefits

The Plan will send you information on the mail order drug program. To use the program:

1) Complete the initial mail order form.
2) Enclose your prescription and copayment.
3) Mail your order to: Caremark, P. O. Box 659572, San Antonio, TX 78265-9572
4) Allow approximately two to three weeks for delivery.

You'll receive forms for refills and future prescription orders each time that you receive drugs or supplies under this program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: 1-800/831-4440.

Drugs from other sources

Prescription drugs are also covered at **75%** after the $250 deductible has been met under this Plan when they are provided to you by a doctor or covered facility.

Purchasing drugs when you are in a foreign country

Only prescription drugs and supplies available in the United States and listed above as covered by the Plan are eligible for reimbursement when purchased in a foreign country. These expenses are reimbursed at **75%** after the $250 deductible has been met.

Dental Benefits

What is covered

The Plan will pay for the following services on the Class A and Class B schedules of dental allowances. These lists include all covered services.

Preventive care

Class A schedule of dental allowances

The Plan pays actual charges for up to two visits per person per calendar year up to the amounts specified below; you pay any charges that exceed Plan payment.

Oral exam	$12.50	Complete X-ray series	$34.00
Prophylaxis, adult	$22.00	Panoramic X-ray	$34.00
Prophylaxis, child (thru age 14)	$15.00	Single film X-ray	$ 5.50
with fluoride treatment	$24.00	Each additional X-ray film (up to 7)	$ 4.00
Space maintainer	$88.00	Bitewings – 2 films	$ 9.00
		Bitewings – 4 films	$14.00

Restorative care

Class B schedule of dental allowances

After you pay a deductible of $50 per person per calendar year and any charges that exceed Plan payment; the Plan pays actual charges up to the amounts specified below.

Restorations		**Root canal therapy**	
Amalgam – 1 surface deciduous	$12.50	One root	$106.00
Amalgam – 2 surfaces deciduous	$18.50	Two roots	$126.00
Amalgam – 3 or more surfaces deciduous	$23.50	Three or more roots	$170.00
Amalgam – 1 surface permanent	$14.00	Gingival curettage (per quadrant)	$ 26.50
Amalgam – 2 surfaces permanent	$20.50	**Crowns**	
Amalgam – 3 or more surface permanent	$26.50	Plastic with gold	$120.00
Silicate cement	$13.50	Porcelain	$113.50
Acrylic or plastic	$21.50	Porcelain with gold	$120.00
Gold	$103.50	Gold (full cast)	$120.00
Extractions (uncomplicated)		Gold (3/4 cast)	$120.00
Single tooth	$16.00	Stainless steel	$ 21.50
Each additional tooth	$15.00	**Dentures**	
Pulp capping – direct	$ 9.50	Complete upper or lower	$126.00
Pulpotomy – vital	$21.00	Partial without bar	$138.00
Pontics		Partial with bar	$157.00
Porcelain fused to gold	$120.00	Repairs	$ 14.00
Dowel pin	$ 25.00	Relining	$ 40.50

Where this schedule provides for a category of service, but does not specifically list a particular procedure belonging in that category, the Plan will determine the maximum allowance for that procedure. Services of a dentist are not covered under any other Plan benefit except as described above and on pages 14 and 20.

Related benefits

Dental accident

For dental accident benefit, see page 20.

Oral surgery

For covered oral surgery, see page 14.

What is not covered

- Charges related to orthodontia
- Dental procedures involving the preparation of the mouth for dentures, including routine tooth extractions
- Dental implants
- Dental appliances, study models, splints and other devices or services related to the treatment of TMJ dysfunction
- Other dental services not listed as covered
- Any service covered under another provision of the Plan

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copayment charges, etc. These benefits are not subject to the FEHB disputed claims review procedure**.**

Long term care insurance

Long term care is open to NRLCA members, their spouse, parents and parents-in-law under the age of 80. Premium rates are based on your age at the time of approval for coverage. Please consult the separate descriptive pamphlet for detailed information.

- Covers confinements for skilled nursing, intermediate nursing and custodial care, $100 per day benefit
- Covers nonconfinement care for home health care, adult day care and respite care, $50 per day benefit
- Includes return of premium feature
- Includes inflation protection option

Term life insurance

Term life insurance is open to active postal employees who are members of the NRLCA under age 60. Premium rates are based on your age at time of approval for coverage and at each renewal date. Please consult the separate descriptive pamphlet for detailed information.

- Provides up to $200,000 of term life insurance coverage in $25,000 multiples
- Provides up to $40,000 accidental death and dismemberment coverage
- Family life insurance coverage up to $10,000
- Living Care benefit for terminally ill enrollees

Long term disability income insurance

Long term disability income insurance protects an individual from being unable to work because of an illness on injury. Long term disability coverage is available to active regular rural letter carriers that are members of the NRLCA. Premium rates are based on your age and benefit level selected. Please consult the separate descriptive pamphlet for detailed information.

- Two benefit levels with a waiting period
- Replacement of up to 60% of basic pay tax-free
- Benefits payable to age 65
- Premiums payable through payroll allotment

For further information on any of the above benefits, contact the NRLCA Insurance Department at:

NRLCA Group Insurance Department
1630 Duke Street**,** First Floor
Alexandria, VA 22314-3466
1-703/684-5552

Benefits on this page are not part of the FEHB contract

Section 6–How to File a claim

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Plan at 1-703/684-5552 to report the delay. This is also the number to call for claim forms or advice on filing claims. Until you receive your identification card(s), use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services.

If you have a question concerning Plan benefits, contact the Carrier at 1-800/638-8432.

Claim forms will be furnished with your identification cards. Claim forms will also be furnished with all claim payments. Additional forms may be obtained by writing to the Plan at 1630 Duke Street, First Floor, Alexandria, VA 22314-3466 or calling 1-800/638-8432.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA 1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA 1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name and address of person or firm providing the service or supply
- Date(s) on which services or supplies were furnished
- Type of each service or supply and the charge
- Diagnosis

In addition:

- A copy of the explanation of benefits (EOB) or Medicare Summary Notice (MSN) from any primary payer must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and medicines that are not ordered through the mail order drug program must include receipts that include the prescription number, name of drug, prescribing doctor's name, date, charge and name of the pharmacy.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. Dollars using the exchange rate applicable at the time the expense was incurred.
- If the claim involves hospitalization, the hospital billing statement must show (or the hospital must advise) the type of accommodations (private, semiprivate, etc.). If a private room is used, the billing statement must show the average semiprivate rate.

Canceled checks, cash register receipts or balance due statements are not acceptable.

Complete a claim form HCFA 1500. Note the name of the insured the same as it appears on the ID card. Be sure to answer all questions or mark "Not Applicable" (N/A) on those which do not apply every time you file a claim.

The attending doctor or dentist must complete the statement on the HCFA 1500 or furnish another statement which includes the name of the patient, the diagnosis, dates of treatment, itemized charges and the Federal Tax ID number of the doctor or dentist. There is no separate prescription drug or dental claim form.

After completing claim form HCFA 1500 and attaching the doctor's or dentist's statement and all related itemized bills, send claims to:

Rural Carrier Benefit Plan
P. O. Box 668329
Charlotte, NC 28266-8329
Claims toll-free telephone number: 1-800/638-8432
Plan Administrative Office telephone number: 1-703/684-5552

Records

Keep a separate record of the medical expenses of each covered family member, as deductibles and maximum allowances apply separately to each person. Save all medical bills including those being accumulated to satisfy a deductible. In most instances they will serve as evidence of your claim. The Carrier will not provide duplicate or year-end statements.

Submit claims promptly

Claims must be filed within 90 days after the expense for which the claim is being made was incurred. To avoid delays in payment, submit claims as expenses are incurred. **Do not hold claims until the end of the year**. Expenses are "incurred" on the date on which the service or supply is received. No benefits are payable for claims submitted to the Plan more than two years from the date the expense is incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

A finding of custodial care by the Plan does not exclude benefits for all services and supplies. Some services (such as prescription drugs, X-rays and lab tests) may still be covered. **ALL BILLS SHOULD BE ROUTINELY SUBMITTED TO THE PLAN FOR CONSIDERATION**.

Once benefits have been paid, there is a three-year limitation on the reissue of uncashed checks.

Direct payment to hospital or provider of care

An assignment to direct benefit payments to the hospital or doctor may be made by completing an assignment form furnished by the hospital or doctor or by completing the assignment statement on claim form HCFA 1500.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Section 7–General Exclusions — Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortion except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses that you incurred while you were not enrolled in this Plan;
- Services, drugs or supplies when no charge would be made if the covered individual had no health insurance coverage;
- Services, drugs or supplies furnished without charge (except as described on page 31) while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions; or (2) during combat;
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, child, brother or sister by blood, marriage, or adoption;
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Charges for services and supplies that are not reasonable and customary;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Part A and/or B (see pages 31 and 32), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) or State premium taxes however applied;
- Acupuncture;
- Custodial care;
- Preventive medical care and services (including periodic checkups and well child care after age 24 months, associated X-ray and lab tests) except as provided under Other Medical Benefits (pages 18 and 19) and Additional Benefits (page 20);
- Weight control or any treatment of obesity except surgery for morbid obesity (ileojejunal, balloon or gastric shunt procedures);
- Programs for smoking cessation and related drugs even if prescribed by a doctor, except as provided under Other Medical Benefits (page 19);
- Inpatient private duty nursing;
- Any services rendered related to a learning disability;
- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning;
- Breast implants (except after mastectomy as provided on pages 15 and 18), injections of silicone or other substances, and all related charges;
- Nonmedical services such as social services and recreational, educational, visual, and speech therapy (except as provided for on pages 18 and 19);
- Hearing aids and examinations for them;
- Eyeglasses and contact lenses (except as covered under Other Medical Benefits on page 18);
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices; and
- Services, drugs or supplies for cosmetic purposes

Section 8–Limitations — Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/638-6833.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this plan and Medicare (see page 31).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare**.**

This Plan is primary if:

1) You are age 65 or over**,** have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD), except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are 65 or over and (a) you are a Federal judge who retired under title 28 of the U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26 of the U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
5) You are enrolled in Part B only, regardless of your employment status;
6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation Programs has determined that you are unable to return to duty;
8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1 through 7 above.

When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the coinsurance.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to medical care. Note: Medicare does not cover outpatient prescription drugs; therefore, neither the deductible nor the coinsurance for prescription drugs is waived.

Prescription Drugs: If you are enrolled in Medicare Part B, this Plan will reduce the copayment you pay under the Rural Carrier mail order drug program from $10 to $2 per prescription for generic prescriptions and from $15 to $5 for brand name prescriptions.

Dental Benefits: A person enrolled in Medicare is required to satisfy the dental deductible.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare**.**

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

When you also enroll in a Medicare+Choice plan

When you are enrolled in a Medicare+Choice plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims**.**

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the limiting charge, is 115% of the Medicare-approved amount. Under this law**,** if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Summary Notice (MSN) form will have more information about this limit.

If your doctor does not participate with Medicare and asks you to pay more than the limiting charge, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare MSN statement. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115% of the Medicare-approved amount.

How to claim benefits

In most cases, when both Medicare and this Plan cover services, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee**.** When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with all Medicare Part B carriers to receive electronic copies of your claims after Medicare has paid their benefits. This eliminates the need for you to submit your Part B claims to this Carrier. You may call the Carrier at 1-800/638-8432 to find out if your claims are being electronically filed. If they are not, you should initially submit your claims to Medicare and, after Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses upon receipt of the itemized bill and Medicare Summary Notice (MSN) statement. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare MSN statement.

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay. After the first plan pays, we will pay either what is left of the reasonable and customary charge or our regular benefit, whichever is less. We will not pay more than the reasonable and customary charge.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

When others are responsible for injuries

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation describes the Plan's right to recover any payments made to you or your dependent by a third party's insurer, because of an injury or illness caused by a third party. Third party means another person or organization.

If you or your dependent receive Plan benefits and have a right to recover damages from a third party, the Plan is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. Any remainder will

be yours or your dependents. The Plan's share of the recovery will not be reduced because of attorney's fees, or because you or your dependent has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

You must promptly advise the Plan whenever a claim is made against a third party with respect to any loss for which Plan benefits have been or will be paid. You or your dependent must execute any assignments, liens or other documents and provide information as the Plan requests. Plan benefits may be withheld until documents or information is received.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits. We are entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by us that were later found to be payable by OWCP (or the agency).

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State or Federal Government agency directly or indirectly pays for.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Limit on your costs if you're 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position that confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800/638-8432 for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. The Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible or coinsurance.

If your physician participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 85% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 15% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance amount, and any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800/638-8432 for assistance.

Section 9–Fee-for-Service plan facts

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after the calendar year deductible is met, when out-of-pocket expenses in that calendar year exceed $2,000 per person or $2,500 per family in PPO benefits. The out-of-pocket expense limits for Non-PPO benefits are $2,500 per person or $3,000 per family. Any expenses incurred through PPO or Non-PPO benefits apply toward both catastrophic limits.

Out-of-pocket expenses for the purposes of this benefit are:

- The 10% (PPO) and the 15% (Non-PPO) you pay for Surgical Benefits;
- The 20% (Non-PPO) you pay for Inpatient Hospital Benefits;
- The 15% (PPO) and 25% (Non-PPO) you pay for Other Medical Benefits;
- The $250 you pay toward the Other Medical Benefits calendar year deductible;
- The $200 (non-PPO) you pay toward the first hospital admission deductible under Inpatient Hospital Benefits.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- The $15 copayment (PPO) for doctor office visits;
- Expenses for mental conditions, substance abuse or dental care;
- Expenses incurred for medications ordered through the Rural Carrier mail order drug program;
- Expenses for non-covered services and supplies;
- Expenses for confinement in a skilled nursing facility; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see page 34).

Mental Conditions/ Substance Abuse Benefit

For Mental conditions, after the **20%** you pay for inpatient care, plus the $200 deductible, total $8,000 in a calendar year for an individual, the Plan will then pay **100%** of covered hospital charges for that individual for the remainder of the calendar year.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits. Benefit changes are effective on January 1.

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. It is your responsibility to ensure that precertification is obtained. If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call Mutual of Omaha's Care Review Unit at least seven days prior to admission. The toll-free number is 1-800/228-0286.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

Mutual of Omaha's Care Review Unit will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 29 and 30). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/228-0286 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits payable for the admission will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the date of a maternity or emergency admission or in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

Precertify home health care, hospice care and skilled nursing care

When home health care, hospice care or skilled nursing care are prescribed by a doctor, you, your representative, the doctor, the home health agency, hospice agency, or skilled nursing facility must telephone Mutual of Omaha's Care Review Unit at 1-800/228-0286 for a predetermination that, based on the information given, the care meets the medical necessity requirements of the Carrier. Otherwise, benefits payable for the care will be reduced.

Definitions

Accidental injury

An injury caused by an external force such as a blow or a fall and that requires immediate medical attention. Animal bites and poisonings are also included as is dental care required as a result of an accidental injury to sound natural teeth. An injury to the teeth while eating is not considered an accidental injury.

Admission

The period from entry into a hospital (admission) or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Confinement

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new confinement when an admission is: (1) for a cause entirely unrelated to the cause for the previous admission; (2) for an enrolled employee who returns to work for at least one day before the next admission; or (3) for a dependent or annuitant when confinements are separated by at least 60 days.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include cleft lips, cleft palates, birth marks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking, getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2) homemaking, such as preparing meals or special diets;
3) moving the patient;
4) acting as companion or sitter;
5) supervising medication that can usually be self administered; or
6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your attending doctor;
2) are medically necessary;
3) are primarily and customarily used only for a medical purpose;
4) are generally useful only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Section 9–Fee-for-Service plan facts *continued*

Effective date

The date the benefits described in this brochure are effective:

1) January 1 for continuing enrollments; or
2) for new enrollees in the Plan, the effective date of enrollment is determined by the employing office or retirement system of the enrollee.

Expense

The cost incurred for a covered service or supply ordered or prescribed by a doctor. An expense is incurred on the date the service or supply is received. Expense does not include any charge: 1) for a service or supply that is not medically necessary, or 2) that is in excess of the reasonable and customary charge for the service or supply.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Home health care

A plan of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without home health care, confinement in a hospital or skilled nursing facility would be required. Home health care must be provided by a public agency or private organization that is licensed as a home health agency by the State and is certified (or is qualified and could be certified) as such under Medicare.

Hospice care program

A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family, provided by a medically supervised team under the direction of a Carrier approved independent hospice administration.

Medical emergency

The sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical care that the covered person secures within 5 days after the onset. Medical emergencies include deep cuts, broken bones, heart attacks, cardiovascular accidents (strokes), poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Carrier to be medical emergencies.

Medically necessary

Services, drugs**,** supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:

1) are appropriate to diagnose or treat the patient's condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Carrier; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Morbid obesity

A condition in which an individual:

1) is greater than 100 pounds or 100% over the standard weight as determined by the Carrier's underwriter, with complicating medical condition(s), and
2) has been so for at least five years, despite documented unsuccessful attempts to reduce weight under a diet and exercise program monitored by a doctor.

Section 9–Fee-for-Service plan facts *continued*

Prosthetic appliance

A device which is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. Prosthetic appliances include such items as artificial legs, artificial hips, artificial knees, and pacemakers.

Reasonable and customary

Those charges that are comparable to charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area. The Carrier's allowances are developed from actual claims received in each zip code area throughout the United States, as compiled by the Health Insurance Association of America, and are updated twice a year, at the 90th percentile. This method is used for determining reasonable and customary allowances for surgery, maternity, physician and other professional services, Other Medical and Mental Conditions/Substance Abuse Benefits, and accidental injury care. For other categories of benefits, and for certain specific services within each of the above categories, exceptions to this general method for determining the Plan's allowances may exist.

Sound natural tooth

A tooth that is whole or properly restored and is without impairment, periodontal disorders or other dental disorders and is not in need of the treatment provided for any reason other than an accidental injury.

Section 10–FEHB Facts

You have a right to the following information

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan and its networks of providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental and investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800/638-8432 or write to:

Rural Carrier Benefit Plan
1630 Duke Street, First Floor
Alexandria, VA 22314-3466

You may also contact us by fax at 1-703/684-9627, or visit our website at www.nrlca.org

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a Guide to Federal Employees Health Benefits Plans, brochures for other plans and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family member;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and in most cases cannot change your enrollment status without information from your employing or retirement office.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage, which is described later in this section.

What types of coverage are available for me and my family?

Self-Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who became incapable of self-support before 22.

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Are my medical and claims records confidential?

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and our subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP) when coordinating benefit payments and subrogation claims;
- Your physician(s), when reviewing your prescription drug usage under the Plan's prescription drug program;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Registration Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in this Plan ends?

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your spouse's coverage. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your spouse's employing or retirement office to get more information about your coverage choices.

What is Temporary Continuation of Coverage (TCC)?

If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the booklet RI 79-27, which describes TCC, and the RI 70-5, Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan.
- If you leave Federal service, you can receive TCC for up to 18 months after you separate.
- If you no longer qualify as a family member, you can receive TCC for up to 36 months.
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.

- You pay the total premium, and generally a 2% administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying your premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce; or
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notifies your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay the premium, you cannot convert.
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice.

However, if you are a family member who is losing coverage, the employing or retirement office will not notify you, nor will we.You must apply in writing to us within 31 days after you are no longer eligible for coverage. Send your request to:

NRLCA Insurance Department
1630 Duke Street, First Floor
Alexandria, VA 22314-3466

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/638-8432 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
1-202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member, or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Notes

Summary of Benefits for the Rural Carrier Benefit Plan — 2000

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO:** 100% of hospital charges, no deductible	11,12
		Non-PPO: After $200 deductible per person for the first admission in a calendar year, 100% of room and board and 80% of all other covered hospital charges	11,12
	Surgical	**PPO:** 90% of the provider's negotiated fee	13,14
		Non-PPO: 85% of reasonable and customary charges	13,14
	Medical	**PPO:** 85%* of the provider's negotiated fee; $15 copayment per doctor office visit (no deductible)	18-20
		Non-PPO: 75%* of reasonable and customary charges	18-20
	Maternity	Same benefits as for illness and injury	15,16
	Mental conditions	**PPO:** 100% of covered hospital charges, no deductible	16,17
		Non-PPO: After a $200 deductible per person, for the first admission in a calendar year, 100% of room and board and 80% of other covered hospital charges	16,17
	Substance abuse	**PPO:** Up to $6,000 per treatment program, including aftercare, in an accredited alcohol or drug abuse treatment facility (limited to two treatment programs per lifetime)	17
		Non-PPO: Up to $5,500 per treatment program, including aftercare, in an accredited alcohol or drug abuse treatment facility (limited to two treatment programs per lifetime)	17
Outpatient care	**Hospital**	**PPO:** 100% for surgery facility, 85%* of other hospital charges	18,21
		Non-PPO: 100% of reasonable and customary charges for surgery facility, 75%* of other hospital charge	18,21
	Surgical	**PPO:** 90% of provider's negotiated fee	13,14
		Non-PPO: 85% of reasonable and customary charges	13,14
	Medical	**PPO:** 85%* of provider's negotiated fee	18-20
		Non-PPO: 75%* of reasonable and customary charges	18-20
	Maternity	Same benefits as for illness and injury	15,16
	Home health care	100% of the reasonable and customary charges up to a maximum of $80 per visit for up to 90 visits in a calendar year	21
	Mental conditions	Up to $75 per session (not subject to deductible or coinsurance)	17
	Substance abuse	**PPO:** Up to $6,000 for an aftercare treatment program	17
		Non-PPO: Up to $5,500 for an aftercare treatment program	17
Emergency care		**PPO:** Up to $500 of charges for treatment of injury that was incurred within 5 days of the accidental injury	20
		Non-PPO: Up to $300 of charges for treatment of injury that was incurred within 5 days of the accidental injury	20
Prescription drugs		The Plan pays 75%* and you pay 25% of reasonable and customary charges. Under the mail order drug program, you pay $10 generic, $15 brand name per prescription or refill ($2 generic, $5 brand name if you are covered by Part B of Medicare)	22
Dental care		Benefits for preventive and restorative services listed on dental schedules	23
Additional benefits		Hospice care, Home Health care, Vision care, Cancer treatment, Childhood immunizations, Renal dialysis, Skilled nursing facility care, Dental accident	20,21
Out-of-pocket maximum		100% of covered charges under Inpatient Hospital, Surgical and Other Medical Benefits after expenses reach $2,000 (PPO), $2,500 (Non-PPO) out-of-pocket per individual or $2,500 (PPO), $3,000 (Non-PPO) per family in a calendar year or after you spend $8,000 on covered hospital charges under Mental conditions for one person in a calendar year	32,33

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Federal Employees Health Benefits Program

2000 Rate Information for Rural Carrier Benefit Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definition in "The Guide to Federal Employees Health Benefit Plans for United States Postal Employees," RI 70-2, to determine which rate applies.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
High Option Self Only	**381**	**n/a**	**n/a**	**$170.80**	**$ 86.71**	**$ 93.06**	**$25.79**	**$ 93.26**	**$25.59**
High Option Self and Family	**382**	**n/a**	**n/a**	**$381.27**	**$143.71**	**$207.74**	**$34.56**	**$201.02**	**$41.28**